Office Use Only: [check box] is this for a phase II dental service? Y N

If yes – staff required to collect income verification.

Thundermist HEALTH CENTER

Sliding Fee Discount Program Form

We will care for you even if you cannot pay. You may be eligible for discounts based on income and family size. Discounts are available, even if you have insurance.

Patient Name: _____ Patient Date of Birth: _____

1. Including yourself, what is the size of your family? (Use definition below)
   _____
2. What is the total annual income of those included in your family in Question #1?

   $ _____ ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Annually
3. Please select 1 (one) option below:

☐ I certify the information entered above is correct to the best of my knowledge. I agree to inform Thundermist if my family size or income changes. I understand changes to my family size or income may change if I am eligible for the Thundermist Sliding Fee Discount Program.

☐ I do not want to participate in the Thundermist Sliding Fee Discount Program.

Print Responsible Party Name (If other than Patient) Date

Responsible Party Signature Date

*Family Size: Include yourself and other people related by birth, marriage, or adoption who live together. Family also includes unrelated people who live in the same household and are supported by or supporting a member of the family. Foster children are not included in Family Size.